STATELO	n of Health Care Fac				FORM	APPRO	
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DAT	E SURVEY	
C. C. C. Comm. S. Maria		OCCUPANTOR NOWBER:	A BUILDING: 01 - MAIN BUILDING 01		COMPLETED		
					1		
	TN4714		B. WING		12/	12/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE, ZIP CODE			1 12 14 12017	
TENNOV	A HEALTH CARE-TE		T OAK HILL A				
·		KNOXV	LLE, TN 3791	7			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF COR		RRECTION	RECTION (X	
	REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPL	
	<u> </u>			DEFICIENCY)	AFEROPMATE	DAT	
N 002	1200-8-6 No Defici	encies	N 002				
			1 1002			1	
1	During the Life Set	NAC MANAGEMENT OF SE					
ļ	During the Life Safety portion of the annual Licensure survey conducted on December 15,						
	2014, no deficiencies were cited under		'			1	
	1200-08-6, Standar	ds for Nursing Homes.	1			İ	
		in the same of the					
			1			•	
			1 .				
					 !		
			1				
			1				
	•						
			!		ļ		
	•				Í		
		j					
			Ī				
		1	ŀ				
		J	f				
			ļ				
			ı				
					i		
		į					
			1		Į		
			Ì		ļ		
ĺ		1			Ï		
		1					
ŀ			i •				
of Healt	h Care Facilities					<del></del>	
AFORY DII }	RECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	t×	B) DATE	
Frank.	L. Pucar			HHA	1/2/		

D81V21